Abstract.

The Michigan Certified Community Behavioral Health Planning Grant project is a collaboration among the Behavioral Health And Developmental Disabilities Administration (BHDDA), the Michigan Association of Community Mental Health Boards (MACMHB), and the Michigan Medicaid Services Administration (MSA) to develop the criteria for a certification process and prospective payment program that will more effectively serve individuals of all ages with behavioral health conditions in Michigan. This initiative will address the needs of individuals in urban and rural communities, with particular focus on those with health disparities. Michigan currently ranks 41st out of 50 states in prevalence of mental health issues (high) as compared to access to care (low), and 44th when ranked on the same measure for youth. Rates of depressive episodes in the past year are 10.2% in MI compared to the national average of 9.9%, and rates of suicidal thoughts among adults are a full percentage point higher than the national average (4.5% v. 3.9%). Illicit drug use among adolescents, dependence among individuals 12 and older, binge drinking, alcohol dependence, and heavy alcohol use are all higher than national averages. In Southeastern Michigan specifically, 18.3% of individuals who identify as American Indian/ Alaskan Native (AI/AN) reported at least 14 poor mental health days in the past 30 days (as compared to 11.2% of the general population in this same area).

The proposed CCBHC planning process will effectively leverage Michigan's existing Dual Eligibles Demonstration program, two 2703 State Plan Amendments on Health Homes, and Michigan's State Innovation Model Testing grant in order to enhance access to integrated, coordinated, and person-centered behavioral health care statewide. Planned activities include expansion of our CCBHC Steering Committee, implementation of a formal stakeholder engagement process, technical assistance and support for potential CCBHC clinics, design of a prospective payment system that incentivizes performance (PPS-2), upgrade of information systems to support care coordination and PPS billing, design and execution of a certification process, certification of up to ten (10) CCBHCs, data collection in accordance with the state and national project evaluation, and application to participate in the CCBHC demonstration. The steering committee will seek input and partnerships from stakeholders including Veterans' organizations and Native American tribes.

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Section A: Statement of Need

A-1 How Behavioral Health Services are Organized, Funded, and Provided in MI.

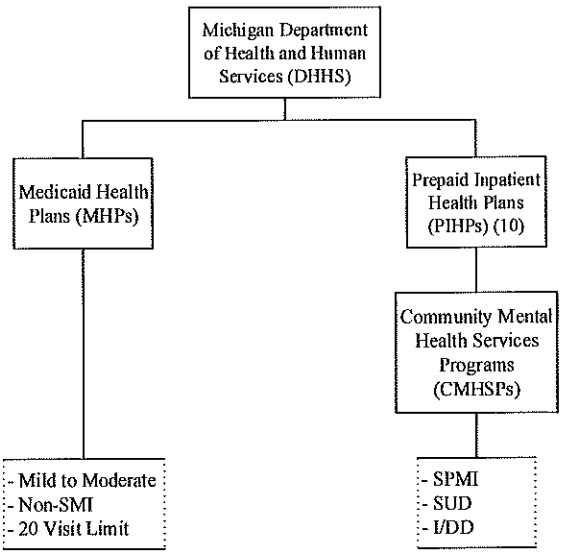
In Michigan, behavioral health prevention, early identification, treatment, and recovery support systems are the primary responsibility of the State's mental health and substance use disorder services authorities, collectively known as the Behavioral Health and Developmental Disabilities Administration (BHDDA), located within the Michigan Department of Health and Human Services (MDHHS). The Medical Services Administration (MSA) within MDHHS is the State Medicaid Agency (SMA). MSA's primary responsibility is oversight of Michigan's Medicaid program. MSA manages comprehensive physical health services, inclusive of outpatient mental health, for individuals with mild to moderate mental health needs through managed health plans (MHPs) that contract with MDHHS. In April 2014, Michigan expanded Medicaid by creating the Healthy Michigan Plan. Currently, more than 590,000 Michigan residents are enrolled and are receiving both comprehensive physical and behavioral health outpatient services, including access to the full continuum of specialty behavioral health services.

BHDDA, which encompasses the Bureau of Substance Abuse and Addiction Services (BSAAS), is responsible for administration of state SUD appropriations, the Substance Abuse Prevention and Treatment Block Grant, and the Mental Health Block Grant. BHDDA carries out responsibilities specified in the Michigan Mental Health Code and the Michigan Public Health Code. BHDDA, in partnership with MSA, also administers the Medicaid specialty services benefit for people with intellectual/developmental disabilities (IDD), adults with serious mental illness (SMI), children with serious emotional disturbance (SED), and individuals with SUD.

Public behavioral health services in Michigan are delivered through county-based community mental health services programs (CMHSPs) which are public entities created by county governments to provide a comprehensive array of mental health services to meet local needs, regardless of an individual's ability to pay. CMHSPs provide Medicaid, state general fund, block grant, and locally funded services to children SED, adults with SMI, and children and adults with I/DD. These services are either provided directly by the CMHSP or through contracts with providers in the community. Some CMHSPs also contract for direct provision of outpatient and other SUD treatment services (residential, detox, inpatient rehabilitation).

CMHSP's contract with Prepaid Inpatient Health Plans (PIHPs) which – on behalf of MDHHS – serve as the state's publicly-operated managed behavioral health system for Medicaid-funded behavioral health specialty services and supports. PIHPs are also the responsible entities for directly managing Substance Use Block Grant funding and local substance abuse funding. Ten regionalized PIHPs operate throughout the state and contract directly with MDHHS. A visual depiction of the MDHHS, PIHP, and CMHSP structure is in Figure 1:

Figure 1 - Visual Depiction of MDHHS, PIHP, CMS Structure



Michigan is committed to working with SAMHSA during the CCBHC Planning Year as we use the CCBHC planning grant to align the planning and implementation with complementary initiatives in the state to improve outcomes and quality, including the Demonstration to Integrate Care for Persons Eligible for Medicare and Medicaid, the Centers for Medicare and Medicaid State Innovation Models Initiative (SIM) Testing Grant and Medicaid health homes for individuals with SMI. By managing these initiatives collectively, rather than individually, we hope to accelerate progress toward achieving targeted outcomes, improving the lives of Michiganders, and evolving the behavioral health services infrastructure in the state.

Over the past year, MDHHS has worked in conjunction with its CMHSP and PIHP partners from across the state to develop a set of shared Core Values for delivery and integration of quality behavioral health, developmental disability, and substance abuse services within our social service systems for children and adults in our communities, This vision has guided Michigan's CCBHC submission and is reflected throughout this narrative in our current commitment to integrated and coordinated care, expanded array of safety net services, whole population health, community partnerships, consumer governance, and ongoing evolution for high quality care for all Michigan citizens.

A-2. Describe MI prevalence rates of adults/children with mental illness and/or SUD.
Michigan residents have a higher than average prevalence of mental illness and a lower than average rate of access to care when compared with other states across the country.[i] Michigan currently ranks 41st out of 50 states in prevalence of mental health issues (higher than average) as compared to access to care (lower than average), and we are 44th out of 50 when ranked on the same comparison for youth.[ii] The following table presents prevalence rates of adult and children with mental illness and substance use disorders, including select subpopulations, in the state:

Metric:	*Michigan:*	*United States:*
Mental Health		
Any Mental Illness (AMI) among Adults, ages 18 and over[iii]	19.81%	18.19%
Past-Year Serious Mental Illness (SMI) among Adults aged 18 or Older[iv]	4.7%	4.1%

Past-Year Serious Thoughts of Suicide among Adults, aged 18 or Older[iv]	4.5%	3.9%
Past-Year Major Depressive Episode (MDE) Among Adolescents, ages 12-17[iv]	10.2%	9.9%
Children identified as having a serious emotional disturbance (SED)	12.8%[v]	10%[vi]
Substance Use		
Past month Illicit Drug Use Among Adolescents, ages 12-17[iv]	11.4%	9.2%
Past-Year Illicit Drug Dependence among Individuals, aged 12 and Older[iv]	3.0%	2.7%
Cigarette Use among Adolescents[iv]	7.1%	6.1%
Past Month Binge Alcohol Use Among People Ages 12-20[iv]	15.9%	14.7%
Past-Year Alcohol Dependence or Abuse Among Individuals, aged 12 and Older[iv]	6.8%	6.7%
Past-Month Heavy Alcohol Use among Adults aged 21 or Older[iv]	8.0%	6.8%

The high prevalence of behavioral health concerns compounded by low access to care often results in maladaptive outcomes for our state's residents. Michigan's public mental health system provides services to only 25% of adults who live with SMI in the state.[vii] Suicide, often the result of undertreated or untreated mental illness, was the leading cause of injury death across the state in 2009 for adults,[viii] a rate that increased by an astonishing 41.6% among adults between the ages of 35 and 64 from 1999 to 2010[ix]. Further, in 2009, 16% of Michigan's youth reported having seriously considered suicide, and one in every 11 (9.3%) reported having attempted suicide one or more times.[x] Suicide is the 3rd leading cause of death in the state among residents, aged 1-19 in 2012. Psychoses was the sixth leading reason for hospitalization in Michigan in 2012, outranking both cancer and heart disease on this measure. Michigan also has a much higher rate of psychiatric inpatient utilization (per 1,000) than the U.S. Rate, as well as a much higher rate of hospital readmissions than the U.S. Rate.

Although Michigan is considering certifying CMHSPs across the state as CCBHCs during the planning year (ensuring geographic representation of both urban and rural areas), we recognize that disparities do exist across regions, and we will aim to prioritize underserved areas for participation. In Michigan, 41 of our 83 counties have mental health HPSAs (Health Professional Shortage Areas), almost all of which are in located in rural areas.[xi] Several regions of the State have percentages of residents that report having poor mental health on at least 14 days in the past month that are higher than the State's percentage (12.7%), including Region 1 (13.2%), Region 2 (13.2%), Region 5 (13.4%), and Region 8 (14.4%).[xii] These, along with other regional behavioral health considerations, will be taken into account when selecting CCBHCs under this initiative.

A-3. Describe capacity of the current Medicaid State Plan to provide the services listed.
Michigan's Medicaid behavioral health benefit package demonstrates our commitment to ensuring residents live healthy and safe lives and achieve personal recovery through highly integrated and coordinated services and systems. By developing CCBHCs on the existing infrastructure available in the state (i.e., health homes), individuals seeking care in the state will have timely access to appropriate levels of service, better integrated services, and delivery designed to ensure their active participation in the planning and evaluation of their care.

In April of this year, in preparation for SAMHSA's CCBHC planning grant initiative, we completed an analysis that cross referenced CCBHC criteria with our current Medicaid State

Plan, the Michigan Mental Health Code, PIHP and CMHSP contracts, Medicaid Health Plan requirements and other relevant sources. Our analysis confirmed that all of the required CCBHC services listed in the Scope of Services criteria are presently required in Michigan, although enhancement is necessary in multiple areas where only partial compliance is presently possible, including: cultural competence, expanded access (hours and days), consistent timeliness (particularly for SUD services), expanded access/availability of mobile crisis teams, improved access for armed forces personnel and veterans, and enhanced care coordination. These areas of focus, for which we will leverage the CCBHC initiative, are outlined in more detail throughout our application. MDHHS already has a number of mechanisms in place to provide leadership in the coordination of mental health services within the broader system. For example, Michigan has achieved national recognition for its early adoption of person centered planning, which is now central to our core array of services related to integrated care.

A- 4. Describe nature of problem, including service gaps; document need for focus.
Although CMHSP's currently directly deliver or provide by contract many of the services required to be provided by CCBHCs, they are not necessarily provided in the exact manner, with the degree of formality, or within the timeframes required in the RFA. In many of these cases, formalization, training and the development of staff capacity are the largest barriers to bringing these services fully on line and into compliance with the CCBHC requirements; barriers which the CCBHC planning grant could be reasonably expected to help us overcome. Service expansion and enhancement will be necessary for many targeted groups (e.g., racial and ethnic minorities, LGBTQ individuals, residents in rural areas). In addition to the above identified gaps, the following critical areas have been identified as priorities:

Decrease Racial/Ethnic Disparities across Michigan:
Hispanic Individuals. Michigan is home to the second largest Hispanic population in the Midwest, with an estimated 4.4% of the statewide population identifying as Hispanic or Latino. 43% of Michigan's total Hispanic population resides in Southeast Michigan. While the overall Michigan population decreased from 2000-2010, the Hispanic population in the state increased by more than one third (34.7%) during the same time period. Hispanic adults in Michigan experience significant health disparities, including higher rates of un-insurance and higher rates of some behavioral health conditions[xiii]:

	Hispanic	All Michigan Adults
% of individuals reporting having no health care coverage	22.6%	16.6%
% of individuals diagnosed with a depressive disorder in their lifetime	29.4%	20.6%
% of individuals reporting binge drinking in the past month	24.1%	19.2%

Notably, Hispanic adults reported the highest prevalence of binge drinking compared to all other racial/ethnic groups in Michigan. Hispanic adults also reported depression 1.4 times that of White, non-Hispanics and 1.7 times that of Black, non-Hispanics, and the prevalence of depression among Hispanic females (41.0%) was 2.2 times that of Hispanic males (18.6%). Additionally, Hispanic adults (16.8%) reported a higher prevalence of poor mental health than White, non-Hispanics (12.0%) and Black, non-Hispanics (14.9%) in Michigan.

African Americans. 14% of Michigan residents identify as African American, about 70% of whom reside in Southeastern Michigan, particularly in Wayne and Oakland counties.[xiv] Adult African Americans are 20% more likely to report serious psychological distress than adult White Americans,

and they are also more likely to have feelings of sadness, hopelessness, and worthlessness than white adults.[xv] Further, African Americans are nearly twice as likely as non-Hispanic White Americans to be diagnosed with schizophrenia.[xvi] Overall, African Americans account for approximately 25% of the mental health needs, a statistic that is greatly disproportionate to the extent to which they are represented in the general population.[xvii] Inpatient mental health service use was more prevalent among black adults than white adults. In regards to substance use, although African Americans are slightly less likely to need treatment for alcohol use (6.8% versus 7.8%), they are more likely to need treatment for illicit drug use (4.1% versus 3.0%).[xviii] However, cultural barriers limit access to care for some African Americans who tend to rely on family, religious, and social communities for emotional support, rather than turning to health care professionals.[xix] Resulting racial disparities for African Americans living in Michigan are not solely limited to adults. Among Michigan's youngest children ages 4 months to 5 years, parents of African American children were more than one and a half times more likely to indicate that they were concerned about their child's physical, behavioral, or social development than parents of White children (52.0% versus 32.5%).[xx]

Arab Americans. Further, Michigan has the largest concentration of Arab Americans in North America, with an estimated population of over 500,000.[xxi] 80% of these individuals reside in the metropolitan Detroit area. Arab American adults living in Michigan are more likely than all Michigan adults to report being uninsured (25.4% vs. 17.4). An estimated 21.3% of Arab American adults reported poor mental health, at rate that is significantly higher compared to all Michigan adults. Arab American adults had a prevalence of poor mental health 1.9 times that of White, non-Hispanic adults in Michigan. The prevalence of poor physical and mental health tended to increase with age. Arab American adults aged 18-44 years (7.2%) had a significantly lower prevalence of reported poor physical health compared to Arab American adults aged 45-64 years (24.7%) and those aged 65 years and older (23.2%). Lack of insurance coverage, combined with cultural and language differences, creates barriers to receiving appropriate and timely health and behavioral health care services.

American Indians/Alaskan Natives. Michigan is home to a total of twelve federally-acknowledged Indian tribes.[xxii] The American Indian/Alaskan Native (AI/AN) population in Michigan grew by 11.8% between 2000 and 2010, making Michigan one of only 14 states across the country with more than 100,000 AI/AN residents (139,095).[xxiii] For those AI/ANs living in Southeastern Michigan specifically, 18.3% of individuals who identify as AI/AN reported at least 14 poor mental health days in the past 30 days (as compared to 11.2% of the general population in this same area). Further, access to behavioral health care is low, in that one in five (19.8%) AI/AN individual's report that they rarely/never get social emotional support as compared to 7.4% of the general population.

Asian Americans/Pacific Islanders. Asian American/Pacific Islanders account for 2.5% of Michigan's population, and tend to reside in Western and Southeast Michigan.[xxiv] The suicide rates of elderly Asian American women and young Asian American women (15-24 years old) are significantly higher than that of other women of the same ages. Non-English speaking Asian American/Pacific Islanders (AA/PI) have significantly lower odds of receiving needed mental health services than Asian/PIs who speak only English.

Culturally Competent Services for Veterans: Veterans in Michigan also require improved access and service expansion. Michigan has the eighth largest population of veterans in the country. Based on national data that one on five veterans have symptoms of PTSD, depression,

and other mental health issues, and 12% experience substance abuse issues we estimate that approximately 140,000 of Michigan's Veterans could benefit from mental health services and 84,000 could benefit from substance use services. Improved coordination between Veteran Administration (VA) services and non-VA service providers is critical, particularly for those veterans living in rural areas or far from a VA behavioral health service center. Members of the National Guard and Reserves have been identified as particularly underserved (Thomas et al., 2010; Hyman et al, 2012; Valenstein et al, 2014).

Improved Services to the LGBTQ population: Using the National Estimate that approximately 10% of the US population identifies as LGBTQ,[xxv] we can estimate that Michigan has just under 100,000 LGBTQ residents. According to the Institute of Medicine (IOM) (2011), LGBTQ populations are at substantially greater risk for substance abuse and mental health problems. Homosexually active men have reported higher rates of major depression and panic attack syndromes than males who reported no same-sex sexual partners in the past year. Likewise, homosexually active women have reported higher rates of alcohol and drug dependence than their female counterparts who reported no same-sex sexual partners in the past year.[xxvi] In Detroit alone, it is estimated that 800 and 1,000 runaway, homeless, and at-risk LGBTQ youth are living in the city on any given day, and these youth are 8.5 times more likely to commit suicide and 3.5 times more likely to use illegal substances than their peers.[xxvii] There is little available data regarding LGBTQ populations within our state, and program evaluation has been limited among organizations targeting LGBTQ populations as well as mainstream programs that serve LGBTQ clients. However, there is currently an ongoing initiative among four community based agencies (Affirmations Lesbian and Gay Community Center in Ferndale, MI; The Network in Grand Rapids, MI; Perceptions Saginaw Valley in Midland, MI; and KICK-The Agency for Lesbian, Gay, Bi and Transgender African Americans in Detroit) that received funding in May of 2014 to collect and analyze health related data from Michigan's LGBT community through a Wellness Needs Assessment. Where possible, during our Planning year, we will leverage these analyses to inform our efforts that are targeted specifically to the LGBTQ population across our state.

Improved Youth and Adolescent Treatment: As noted above, Michigan's current system of care reflects poor penetration rates for the treatment of youth. Less than 10% of Michigan adolescents with an identified need, receiving substance use disorder (SUD) treatment services. In addition in Michigan approximately 71,046 to 142,092 children ages 9 to 17 may have been eligible for services in the public mental health system in 2013. However data compiled by MDHHS for FY 13 indicates only 42,789 children ages 0-17 were served in the public mental health system. Improvement in identifying and engaging children with SED is needed.

Improved SUD Care Overall: From 2002 to 2013, deaths due to heroin and prescription opiate overdose rose from 213 to 840 (rates of 2.1 to 8.5 per 100,000 population). Recent NSDUH surveys (2012-13) reported that 4.8% of Michigan residents, 12 or older, reported nonmedical use of pain relievers in the past year. Expanded access to Medication Assisted Treatment is necessary in response to an increase in Prescription Opioid Use. Rural communities experience particularly acute gaps in care. According to Census data, the top 3 counties reporting the highest rates of excessive drinking and drug poisoning mortality in Michigan are rural.

Improved Integration of Behavioral and Physical Health Care: Based on data from 2011-2013, seven percent of Michigan Medicaid beneficiaries had 3-4 ED visits in a given year and 4 percent had 5 or more ED visits in any given 12-month period, corresponding to more than 75,000 Medicaid beneficiaries. Proportional rates have been mapped by county to help target intervention planning[xviii]. Recommendations developed by a broad array of stakeholders align directly with the goals of the CCBHC process, including recommendations related to payment reform, expanding access to care coordination, and improving HIT systems (Michigan Department of Community Health High Utilizer Report, 2014).

Section B: Proposed Approach

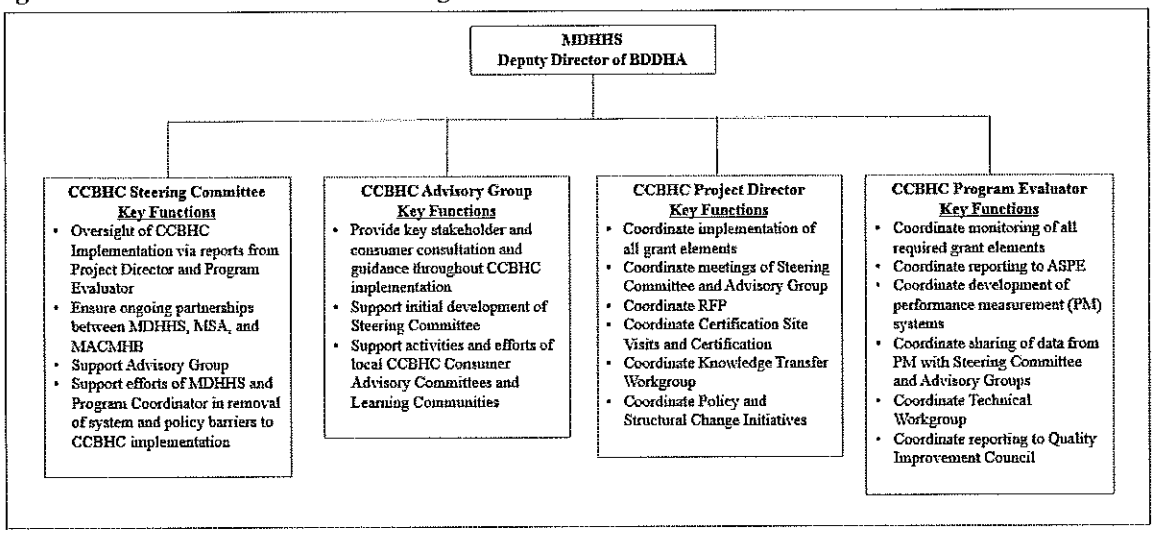
B-1. Describe how capacity, access and services to focus population will be expanded.

Michigan's behavioral health delivery system has made significant strides in recent years to become more recovery-focused and person-centered. Our overarching vision, as expressed in the MDHHS Core Values statement, is to ensure: the integration and coordination of services for improved consumer health outcomes; that community and consumer partners are an integral part of our system; that our efforts support innovation and emphasize the Triple Aim; that our systems makes available the types of services necessary for promoting recovery and resiliency.

Despite these advances, gaps remain between the need and the provision of appropriate care in Michigan. This is particularly true for minority populations, rural communities, and Veterans. Implementing the CCBHC model will drive care transformation and thereby enable the expansion of capacity, access, and availability of behavioral health services in Michigan. Through use planning grant funds, we will design and implement a structure that will: 1) further integrate and/or coordinate mental health, substance abuse, and primary care; 2) improve outreach to those in greatest need and provide care coordination among providers in multiple community settings; 3) enhance accessibility through extended hours, prompt intake and follow-up, and use of innovative service delivery modalities; 4) enhance clinical care delivery by ensuring that staff are trained in core concepts such as person/family-centered, recovery-oriented, culturally competent, evidence-based, and trauma informed care; and 5) address workforce diversity as a way of increasing staff capacity and maximizing the creation of trusted relationships between consumers and care providers.

To accomplish these objectives, we will establish a Statewide CCBHC Planning Framework that will be utilized to support the development, implementation and expansion of CCBHCs in Michigan during the planning grant period and into the demonstration program. The framework will require the creation of a Steering Committee, Advisory Group, and Knowledge Transfer Group as well as identification of key personnel (i.e., Project Director and Program Evaluator) charged with carrying essential project responsibilities. To the extent possible, we will leverage existing resources to fulfill establishment of the CCBHC Planning Framework, preserving grant resources to address CCBHC-specific needs and coordinate across similar initiatives that have parallel objectives. The CCBHC Planning Framework is illustrated in Figure 2. Key functions and roles of the CCBHC Planning Framework is further described in B.2.

Figure 2 - Illustration of CCBHC Planning Framework



Use of the Framework to accomplish outreach, engagement, and coordination:
As Figure 2 portrays, the ***CCBHC Steering Committee*** reports directly to the Deputy Director of BHDDA. It will be fully developed during the planning grant phase, and will include membership from the Behavioral Health Advisory Committee (BHAC), the Medical Care Advisory Council (MCAC), CCBHC leadership, and critical stakeholders in achieving the objectives of CCBHC implementation. The BHAC was established in January 2013 to review the annual combined mental health and substance abuse plan and monitor the allocation and adequacy of mental health and substance use services, while the MCAC was established by Federal law in 2001 to advise MDHHS on policy issues on Medicaid as well as access to care, quality of care and service delivery for managed care and fee for service programs. Existing BHAC and MCAC members will be asked to provide input on the formation of the Steering Committee, including representation from their membership and other critical perspectives essential to the success of CCBHCs. The Steering Committee's primary responsibilities are in ensuring oversight and monitoring of the CCBHC implementation, including reviewing recommendations for Certification and supporting removal of systemic and policy barriers.

A ***CCBHC Advisory Group*** will be created from membership of the current BHAC and MCACs. The primary function of this group will be to provide critical consumer and stakeholder consultation and guidance throughout the CCBHC Implementation. Additionally, two key staff will be hired to coordinate implementation and monitoring of the CCBHC grant during planning grant, demonstration period, and sustained implementation. The ***Project Director*** will be responsible for coordination implementation of all grant elements including RFP, certification, and implementation processes. ***The Program Evaluator*** will ensure monitoring of all phases of the grant including implementation, reporting to SAMHSA, coordinating with ASPE at SAMHSA, data collection, data analysis, and performance improvement planning.

These key groups and individuals will be responsible for coordination and ensured success of CCBHC in Michigan. They will also support implementation of the 5 critical efforts above through 3 strategies: 1) a state-level Steering Committee, 2) regional learning networks and

Consumer Advisory Committees, and 3) ongoing targeted outreach and engagement to Michigan tribal and veterans groups.

Once clinics have been selected to become CCBHCs, learning networks of CCBHC applicants and local consumer advisory committees will be established and participate in a statewide ***Knowledge Transfer Groups***. The Knowledge Transfer Groups will provide a forum for planning and demonstration participants to discuss implementation topics and share best practices. MDHHS will use the CCBHC Planning Framework to facilitate communication between the Knowledge Transfer Groups and local consumer advisory committees.

CCBHC service capacity, access and availability of services will be expanded through use of the Planning Framework, which will enable MDHHS to prepare providers to carry out activities necessary for accomplishing CCBHC objectives and to meet consumer needs. Michigan will work with potential CCBHCs to assess provider readiness and identify training needs, develop and deploy training resources, identify providers' data and reporting capacity, develop protocols for data reporting and submission, and offer necessary training and technical assistance. Through use of the Planning Framework and engagement of provider, consumer and community stakeholders, the state will also support the creation of, and strengthen, relationships with emergency services, medical facilities and primary care providers, human service agencies, non-profit/charitable/faith-based organizations, justice and corrections systems, Veterans Service Organizations, and community organizations with ties to populations that face health inequities.

Accessible Services: CCBHC requirements specify how models of care include extended hours, accessible locations, provision of transportation services, promptness of intake and screening, and tele-health make services more available and reduce barriers for consumers. Some adjustments to state policy will be necessary to meet the CCBHC criteria, although MDHHS will work with CCBHC applicants to adopt models that make sense given local contexts and known best practices. For example, current allowable timelines for accessing SUD services are longer (14 days) than those specified in the CCBHC (10 days), and additional work will also need to be done to increase access to Medication Assisted Treatment in both our rural and urban communities. Additionally, most CMHSPs within the state provide mental health services to veterans, but full coordination of benefit and access to a full array of services requires assessment and problem solving to meet the CCBHC requirements.

Staff Training: CCBHCs and DCOs will be trained in line with the CCBHC model of care. Training will link to service gaps identified in Section A as well as based on needs identified through the readiness assessment. The CCBHC Planning Framework will ensure a focus on crisis response and suicide prevention, cultural competency (for military culture, tribal, and LGBTQ populations), trauma informed care, Recovery Oriented Systems of Care, and for identified evidence based practices (EBPs). Additionally training and development will be necessary to meet new data reporting and workflow requirements related to integrated care coordination and population based planning. MDHHS will develop and share training resources where gaps are identified, and CCBHCs will be required to submit their training plans and skills assessment processes. Throughout the development of Michigan's CCBHC planning project, MDHHS, through implementation of the Knowledge Transfer Group, will seek to document and spread best practices that address community engagement and coordination, accessible services, training

and workforce diversity. MDHHS will develop a website to post EBPs and provide links to a wide range of resources. As described in the following sections, MDHHS will use the Knowledge Transfer Group for CCBHCs to develop quality improvement programs and share lessons learned that will facilitate transformation during the planning and demonstration periods that can be sustained beyond the demonstration.

Workforce Diversity: In order to effectively engage currently unserved populations, such as those who are Hispanic, Arab, African American, and Native American, CCBHCs participate in training and technical assistance provided under the CCBHC Planning Framework to ensure the use of interpretation and translation services as well as auxiliary aids and services to improve cultural competency of service providers; and include cultural competency concepts in staff training as described above. Over and above this, Michigan as a state needs to address workforce sufficiency and diversity. A number of partnerships and efforts are underway and will be leveraged in order to assist CCBHCs in meeting their workforce diversity needs. MDHHS is supporting the use of Community Health Workers (CHWs) by promoting their use by MHPs in addressing social determinants of health, and by promoting incorporation of CHWs in team-based care through its SIM grant. CHWs are recruited from the communities they serve and provide linkages between underserved communities and healthcare opportunities, such as the peer role created by CCBHCs. Additionally, during the planning grant, MDHHS will engage with Michigan's Area Health Education Center (AHEC) to develop proposals to recruit minority health profession students into behavioral health specialties.

B-2. Describe how input on the development of the demonstration program will be solicited from consumers, family members, providers, and other stakeholders including AI/NA.

Consumer, Family Member and Stakeholder Input through the CCBHC Planning Framework

As described in the Planning Framework above, the CCBHC Steering Committee will include consumers, family members, and providers from across the behavioral health, medical health care, and community supports and services spectrum. Furthermore the CCBHC Advisory Group will be entirely comprised of consumers, family members and stakeholders. They will gather input from the local CCBHC Consumer Advisory Groups and feed critical recommendations to both the Steering Committee (through their membership on it) and the Project Director. The Knowledge Transfer Group will work with the CCBHC Advisory Group and local/regional CCBHC Consumer groups to solicit input on recommendations for practice implementation, EBPs, and performance improvement as well as to better understand the needs and recommendations of consumers and stakeholders within the CCBHCs. In this way, MDHHS will use the CCBHC Planning Framework to facilitate communication between the Knowledge Transfer Groups, the CCBHC Advisory Group and local/regional consumer advisory committees. This is consistent with the MDHHS Core Value Statement's extensive emphasis on the role of consumers and stakeholders in the leadership and governance of our system. Furthermore, over 2000 Certified Peer Support Specialists (CPSS) and Certified Recovery Coaches (CRCs) work within our system on a daily basis. These individuals with lived experience in recovery have advanced training in integrated care and are a vibrant voice for consumers in the daily work of our system.

MDHHS will work with potential CCBHCs throughout the planning phase to engage stakeholders at the local level. Systems for coordinating care across agencies and organizations

where challenges exist will be further developed. Local Consumer Advisory Committees at the CCHBSs will be leveraged to facilitate improved efforts at outreach and engagement, collaboration across community agencies and providers and cultural awareness. These groups will be encouraged to examine their membership for representation of critical population groups of emphasis for the CCBHC planning phase and demonstration period.

Targeted Outreach to Solicit Input from Consumers

Although our state model has long emphasized consumer input and leadership, two stakeholder groups will be specifically targeted for more focused outreach during the CCBHC planning grant phase. These include Native Americans and Veterans. Michigan has 12 federally recognized tribes which are independent, self-governing, sovereign nations, each of which has a contract or compact with Indian Health Services to design and determine their own health care system. The goal of initial consultation will be to ensure the CCBHC model is developed to accommodate the needs and organization of tribal members and Tribal Health Centers (respectively), as well as to encourage one or more Tribal Health Centers to participate in the demonstration as a CCBHC. Upon selection of CCBHCs, MDHHS will work with the selected Health Centers and tribal organizations to develop Knowledge Transfer Groups and Consumer Advisory Committees in culturally appropriate ways.

Michigan Governor Rick Snyder has prioritized improving access to services for Veterans through the creation of the Michigan Veterans Affairs Agency (MVAA) within the state Department of Military and Veterans Affairs, as well as through other programs. The CCBHC Project Director will meet regularly with appropriate leadership within the MVAA and Veterans Integrated Service Networks 11 and 12 (covering Michigan's Lower and Upper Peninsula's respectively), who will be asked to nominate representatives for the CCBHC Steering Committee. Veterans and family members will be recruited for the local CCBHC Consumer Advisory Committees through established partnerships with the MVAA Veterans Community Action Teams (VCAT), National Guard family programs office and local armories. The goal will be to develop formal relationships between the CCBHCs and Michigan's 5 VA Medical Centers, outpatient clinics and VHA mental health programs across the state. Because eligibility for veterans' services varies by program and service history, a second goal will be to identify local Veterans Service Organizations and programs that can work with CCBHCs to navigate veterans and service members to appropriate supportive services. Emphasis will also be placed on engaging Veterans who are CPSS and CRCs in this process.

B.3. Describe how community behavioral health clinics will be selected to participate.

Selection Process: As one of the first steps in the planning grant period, the CCBHC Project Director will conduct formal request for information (RFI) to determine the interest and capabilities of potential CCBHC applicants including a self-assessment tool outlining the six CCBHC program requirements and assessing the applicant organizations ability to provide coordinated/integrated care and its capacity to provide those services to persons with mild and moderate mental health and substance use disorders.

Review Process: The Steering Committee or a subset of the Steering Committee (to ensure no potential conflict of interest) will review all initial applications from the RFI to ensure they meet the CCBHC requirements and are compliant in all state and federal requirements. Priority status

for CCBHCs will be given to those organizations who are believed to be most able to quickly address any CCBHC gap areas and meet all new standards and requirement with technical assistance (TA) within the planning grant time period. The RFI process will also be used to identify common systemic, policy, operational and service gaps to guide policy changes, training and TA curriculums, and necessary system solutions that must be addressed during the planning grant phase. Michigan hopes to secure up to 10 CCBHC sites during the planning grant phase, ensuring certification of at least one rural clinic and one urban clinic.

Policy Changes: The Steering Committee with leadership from the Project Director will identify and facilitate necessary policy changes that need to be achieved to ensure CCBHC certification for up to 10 planning grant sites and further sites in the demonstration period and beyond.

Technical Assistance and Support: Following their selection, MDHHS will provide technical assistance and support to each of the CCBHCs to ensure their ability to meet the CCBHC standards on an ongoing basis. The Project Director will work with the CCBHCs to establish Knowledge Transfer Groups so that, based on RFI responses, TA from MDHHS can be planned to meet all CCBHC standards. We will target specific areas for training and TA, which will include implementation of EBPs, performance measurement and reporting, health information technology (HIT) and cultural diversity and competency. BHDDA will also publish learning materials through a web based portal for applicant Q&A and/or requests for further TA. A priority throughout our CCBHC initiative will be to ensure that meaningful consumer input occurs at all levels of the organization, as well as assuring the CCBHC's financial viability and diversity of funding sources to bridge gaps between funding sources and program boundaries.

Certification: Once the list of potential CCBHCs have been identified, a site-based review will be conducted by a special team hired by MDHHS to ensure that data supplied in the needs assessment is consistent with the capacity of the organization to complete the required CCBHC functions or to come into full compliance with the functions during the planning period. The final reports and recommendations of the site visit team will be provided to the CCBHC Steering Committee for formal recommendation of the CCBHC Sites to MDHHS. Up to 10 sites will be recommended by the Steering Committee for formal CCBHC certification Status. The Steering Committee will ensure that, at a minimum, 1 rural and 1 urban site are included in its recommendation to MDHHS. Final authority for certification awards rests with MDHHS. The site review process will further inform the Steering Committee of common gaps that need to be addressed through TA and policy change to support further implementation and expansion of CCBHCs into the Demonstration Period. While Michigan anticipates eventually certifying the majority of its CMHSPs, funding is limited to the two year demonstration; for this reason, supporting applicant readiness will be a significant focus during the RFI process. Ultimately, MDHHS is also interested in certifying Tribal Health Centers and Federally Qualified Health Centers that are able meet the CCBHC requirements. Additional TA may be offered to those organizations to meet the programs expectations.

B.4. Describe how all of the services outlined will be provided by CCBHCs in the state.
Michigan initiated its planning process for the CCBHC in the fall of 2014 by convening a group of interested stakeholders to provide comments on SAMHSA's draft criteria and begin to assess the State's capacity for the CCBHC demonstration program. In May of 2015, we completed an

analysis that cross referenced the CCBHC criteria with the current Medicaid State Plan (including its Health Home State Plan Amendment), the Michigan Mental Health Code, our PIHP Contract, CMHSP contract, Provider Qualification, and MHP requirements. This analysis confirmed that all of the CCBHC services listed in the Scope of Services are presently required in Michigan, although enhancement is necessary in multiple areas where only partial compliance is presently possible. These areas include: cultural competence; expanded access; consistent timeliness, particularly for SUD services; expanded access to/availability of mobile crisis teams; improved access for armed forces personnel and veterans; and enhanced care coordination.

In June, MDHHS disseminated the MTM Certification Criteria Readiness Tool to the CMHSPs around the state, encouraging them each to begin their own readiness assessment process and gap analysis relative to CCBHC required standards. Not surprisingly, preliminary informal feedback supports the results of the formal assessment and analysis described above.

Additionally, because care coordination between physical and behavioral health (including recovery support to address social determinants of health) is the centerpiece of the CCBHC program, CCBHCs will be required to organize and coordinate patient care across a broad array of providers and safety net systems. This demand will require our participating providers to develop contracts that go beyond the traditional memorandum of understanding.

To effectively coordinate these types of services and report quality, cost and encounter data in a timely fashion, CCBHCs will be required to have well developed information technology systems including electronic health records that provide clinical decision support, electronically transmit prescriptions and exchange physical and behavioral health information through HIEs. The MDHHS strongly believes this capability is of the utmost importance and the applicant's ability to meet these standards will be a key component of determining CCBHC certification. Specialized support will be provided to CCBHC applicants during the planning grant phase.

In addition, Michigan requires its CMHSPs, and will expect all CCBHCs, to employ an adequate administrative staffing structure including a Chief Executive officer, Chief Financial Officer, Chief Information Officer, a Medical Director and a Program/Clinical Director deemed sufficient to manage the operational and clinical oversight of CCBHC services. Some of these functions may be provided on behalf of the CCBHC by appropriate administrative entities (e.g., PIHPs for CMHSPs, MHPs for FQHCs) but CCBHCs will need to describe the contractual arrangement.

The state intends to select providers that currently demonstrate the highest capacity within the planning grant period, to deliver the required direct-provided services. This will be balanced with the ability of demonstration sites to positively affect areas of high priority related to disparities identified in earlier sections of this proposal. Michigan also understands that the effectiveness of the CCBHC demonstration will be measured against outcomes expectations enumerated in the PAMA enabling legislation (i.e., whether there was greater access to Medicaid community based MH and SUD services in demonstration areas compared to non-demonstration areas resulting in improved capacity and extended access and availability of services and whether and how CCBHC services had an affected overall MH/SUD costs including inpatient, emergency and ambulatory mental health services).

As such, the state intends to balance provider readiness to become a CCBHC with the need to identify and select geographic areas and populations most in need of greater service access to MH and SUD treatment and support services. In doing so, Michigan will embark on a process, coordinated by the Project Director in partnership with the CCBHC Steering Committee, that assesses the readiness of not only potential CCBHC providers but also of potential DCOs to ensure that the full array of required services are available in a selected geographic area.

The CCBHC planning grant will be used to conduct readiness assessment activities and the development of provider training to strengthen provider service capacity, particularly to ensure the availability and use of EBPs in accordance with fidelity requirements. CCBHC applicants will be requested to estimate their projected service demand for each of the core CCBHC services. Core clinical staffing will be credentialed, certified, and licensed professionals trained in person/family centered planning, cultural competency, trauma informed (including the physical environment where services are delivered) and recovery principals in numbers adequate to meet the required CCBHC services. This will ensure that selected providers are capable of delivering the required services directly or under contract with a DCO in areas of need.

B-5 Identify the evidence-based practices that CCBHCs will be required to provide.
Current Approach to EBPs: Michigan currently takes a two-pronged approach to EBPs to balance statewide policy priorities with local needs and capacity. There are selected EBPs required statewide, although local and regional selection is based upon need and capacity assessment is also required. As such, CMHSPs have implemented a number of EBPs for mental illness and SUD treatment services. CMHSPs and PIHPs have numerous contractual requirements related to the regional and local selection of EBPs. These include requirements to use data driven planning processes and local assessment, inclusive of community, stakeholder and beneficiary input, to expand the use of EBPs, develop epidemiological profiles and logic models, and increase the capacity to address mental, emotional, and behavioral conditions to support and improve the quality of life for citizens of Michigan. The State requires that each specialty PIHP have a quality assessment and performance improvement program (QAPIP). The QAPIP describes the process for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines when there are nationally accepted, or mutually agreed-upon (by MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices and promising practices that are relevant to the persons served. Required evidence-based programs and strategies must be identified that prevent substance use and SUDs; promote mental health; and reduce obesity and infant mortality.

MDHHS will utilize the CCBHC Planning Framework to establish a minimum set of EBPs for implementation by CCBHCs. Those the CCBHC Steering Committee will consider include, but are not limited to: Motivational Interviewing; Cognitive Behavioral individual, group and on-line Therapies (CBT); Trauma Focused CBT (TF-CBT); Dialectical Behavior Therapy (DBT); addiction technologies; recovery supports; first episode early intervention for psychosis; Multi-Systemic Therapy; Assertive Community Treatment (ACT); Forensic Assertive Community Treatment (F-ACT); Wellness Recovery Action Planning; Chronic Disease Self-Management program; evidence-based medication evaluation and management (including but not limited to medications for psychiatric conditions, medication assisted treatment for alcohol and opioid substance use disorders (e.g., buprenorphine, methadone, naltrexone (injectable and oral),

acamprosate, disulfiram, naloxone), prescription long-acting injectable medications for both mental and substance use disorders, and smoking cessation medications); community wrap-around services for youth and children; and specialty clinical interventions to treat mental and substance use disorders experienced by youth (including youth in therapeutic foster care).

Planned Approach for CCBHCs: It is expected that EBPs required as part of the CCBHC initiative will continue to work in partnership with the MDHHS Quality Improvement Council and PIHP and CMHSP Quality Improvement leads throughout the state as well as coordinating with the CCBHC Steering Committee to ensure the objectives of the CCBHC initiative are met. The CCBHC planning grant will assist in monitoring, evaluation and implementation and dissemination of additional EBPs via support for CMHSPs and emphasis on data and outcomes.

Justification: Michigan's shared risk managed care funding model for behavioral health services reinforces the two pronged approach (state-directed and locally/regionally identified) to EBP selection and development. Shared risk and accountability has promoted and reinforced the selection of EBPs that provide improved outcomes at reduced overall cost of services. EBPs currently available statewide (ACT, Wraparound, CPSS, ITCOD, SBIRT) all promote some combination of early intervention/identification, improved coordination and alternatives to more restrictive, costly and debilitating interventions such as hospitalization and institutionalization. This holds true for optional EBPs and will serve as a lens for additional EBPs selected for CCBHC implementation. During the planning phase, MDHHS will develop strategies for reinforcing and training in required EBPs for any non-CMH CCBHC site.

B.6. Describe how the state will certify CCBHCs in both urban and rural areas.
Michigan's Mental Health Code, Act 258 of 1974 (herein referred to as the "Code") section 232a, requires the MDHHS to certify CMHSPs every three years. This certification includes a review of governance, resource management, quality improvement, service delivery and the protection of recipient rights. Although the CMHSP certification process is specifically tailored to these Code requirements, MDHHS intends to expand this certification process to all potential applicants to ensure continued certification compliance as well as the CCBHC requirements. The CMHSP certification process does acknowledge accreditation status and waives certain portions of the CMHSP certification process, but accreditation will not be considered as part of the applicants CCBHC certification. During the planning grant period, the MDHHS will develop a CCBHC application to certify up to 10 CCBHCs that will include both urban and rural geographic areas within Michigan.

Michigan plans to use the national readiness assessment combined with its community behavioral health knowledge of MH/SUD and provider's experiences in achieving and maintain licensure and certification to determine a clinics' capability to successfully carry out the CCBHC program requirements. The state will select geographic areas and identify potential CCBHCs using a variety of approaches including but not limited to: consideration of the array of services currently provided by CMHCs, MHPs and SUD providers and the extent the clinics will have to rely on designating collaborating organizations (to round out the availability to CCBHC services); the use of EBPs; the understanding of the unmet needs of populations (including subpopulations) in order to evaluate the effectiveness of CCBHC's ability to accomplish objectives of the CCBHC; the capacity of providers to report costs associated with development

of the PPS; and other considerations. Special attention in this process will be to ensure that geographic areas examined include both rural and urban clinic options to meet the 1 urban, 1 rural minimum expectation and to maximize ability to develop implementation plans for demonstration that works across the diverse communities and populations within Michigan.

Following evaluation of the readiness assessment, the State will select clinics in accordance with the timeline that aligns with the launch of the CCBHC Demonstration in order to support CCBHC development. Michigan will establish, as appropriate, additional policies to ensure compliance with all of the program requirements for CCBHCs, including the certification of CCBHCs in community behavioral health clinics in a rural or other underserved areas. Michigan plans to provide needed TA to CMHSPs and SUD providers in rural areas for any particular problems such as shortage of qualified staff, transportation, and distance to specialists.

B-7. Describe how state will finalize planning, assist in transition to demonstration.
Through use of the planning grant funds, the state will support development of Knowledge Transfer Groups who will continue to meet to review implementation progress, recommend course corrections, and raise any needs for TA or training to the CCBHC Project Director and CCBHC Steering Committee. In particular, the Knowledge Transfer Groups and governance committees will be monitoring progress of the CCBHC model to address the access and equity concerns. MDHHS will build a knowledge base of best practices for the purpose of statewide dissemination after the demonstration period, and continue to invest in shared training resources for the CCBHCs. By the end of the planning phase, the following milestones will have been achieved, making Michigan ready to succeed in the CCBHC demonstration program:

- MDHHS will have developed a certification program, including established requirements and a process to assess and monitor capacity
- Michigan will have up to 10 CCBHCs, including at least one each within rural and urban areas across the state. Michigan will consider also including at least one FQHC and one Tribal Health Center.
- The CCBHCs will have upgraded information systems in order to document care, participate in Michigan's health information exchange through the sharing of care plans and advance directives, and support PPS billing
- CCBHCs will have written agreements in place to coordinate care with medical providers, and other community organizations.

Towards the end of the planning phase, transitional activities will focus on: 1) ensuring the necessary central administrative systems are in place to manage the demonstration; 2) assessing progress on Health Information Exchange (HIE) and continuing to invest as necessary; 3) addressing programmatic issues related to other parts of the publicly-funded health and human services delivery systems; 4) making any necessary adjustments to the governance model to switch from planning to implementation mode; and 5) developing a plan for taking the successful and improved elements of the model to scale, state-wide.

Administrative systems: Successful administration will require necessary staffing and information systems. Very early in the planning year, adjustments to the state's Medicaid Management Information System (MMIS) and Michigan's Health Provider Directory will be identified and a timeline for changes and testing will be established. Also, the CCBHC Program

Evaluator and CCBHC Knowledge Transfer Group will build mechanisms for ongoing reporting by CCBHCs, and will review its internal staffing model and capacity to monitor and support CCBHCs during the demonstration, as well as report to SAMHSA.

Health Information Exchange and Data Analytics: The Michigan Health Information Network (MiHIN) is the state authority for electronic health information exchange. MiHIN has worked with multiple CMHSPs to facilitate and initiate electronic exchange with physical health providers. Additionally, most of the PIHPs are qualified data sharing organizations in the MiHIN network. Data analytics and population health management have been aided by the state's creation of a web portal, CareConnect 360 (CC 360), which was created and launched as a care coordination tool. This tool makes information in the Data Warehouse, including behavioral and physical health claims, available to MHPs, PIHPs and CMHSPs. This resource will assist in identifying potential health conditions in individual patients.

At the aggregate level, this tool will be useful to the Program Evaluator in determining quality measures and in trending information at various levels including data specific to PIHP/CMHSP organizations. Though there are some limitations to the use of this tool that are discussed in section D.4., the Workgroup is strategizing around the use of CC360 for tracking data specific to CCBHCs and patients receiving services designated for the demonstration program.

Programmatic Integration: Implementing care coordination and new payment models within CCBHCs will require adjustments in roles and responsibilities of other elements of Michigan's payment and service delivery systems, including MHPs, PIHPs, FQHCs, local health departments, local social services supports, private providers and Accountable Systems of Care (ASCs). The impact on these and other entities will be assessed specifically in relation to: MHP and PIHP capitation rates, enrollment in an MHP, processes for selection/assignment of PCPs, and responsibility for Care Management. ASCs are similar to ACOs, but have some unique elements. They are being tested in certain regions as part of Michigan's SIM implementation.

Governance and Rapid Cycle Learning: As Michigan moves from planning to demonstration, MDHHS will take stock of systems in place for governance, rapid cycle learning and evaluation, and make necessary adjustments. The Knowledge Transfer Groups in conjunction with the Steering Committee will be critical in supporting these processes. The governance model will be assessed to ensure appropriate voices are represented, that meaningful consumer input is surfaced, that Steering and Consumer Advisory Committee members find the process effective. The Knowledge Transfer Groups will continue to meet to review implementation progress, recommend course corrections, and surface any needs for TA or training. MDHHS will build a knowledge base of best practices for the purpose of statewide dissemination after the demonstration period, and continue to invest in shared training resources for the CCBHCs.

B.8 – Describe and justify the selection of the PPS rate-setting methodology. Describe how CCBHCs base cost with supporting data, as specified in Appendix III will be collected.
Michigan has decided to pursue PPS-2 as the prospective payment system for the CCBHC sites. The Michigan behavioral health system is currently under a concurrent 1915b/c waiver authority. The PIHPs are paid on a monthly capitated basis. We believe PPS-2 is most similar to existing

practices used in the reimbursement of the 10 PIHPs participating in the specialty services waiver and build. We will extend this capitation methodology and process to the CCBHCs.

In the current rate setting process, base costs are summarized and incorporated into the development of the prospective capitation rates. Base cost information is derived from a cost reporting system in the behavioral health system that is already very robust. Not only is there a cost reporting methodology for the entire clinic system called the "sub-element report", but there is a Medicaid-specific report that breaks out services and cost at a granular level, including by procedure code. This report is called the Medicaid Utilization and Net Cost report (MUNC). Both of these reports are reconciled to the PIHP financial statements and adhere to the cost principles and documentation requirements described in Appendix III of the RFA. We currently have over 5 years of data that we consider to be credible for analyzing historical cost changes. Given how granular and robust the current data infrastructure is, we feel PPS-2 is a natural extension for the Michigan system.

In addition to the MUNC report, the PIHPs are also required to submit encounter data. Encounter data is currently collected at the CMHSP level and evaluated against the data in the MUNC. Recently, the State has invested heavily in improving the quality of the encounter data submitted by the PIHPs. Each PIHP in the state can see their CMHSPs' encounter data and how it compares to the statewide composite through a web-based tool provided by the consulting actuary. Analytics generated from the encounter data allow the State to understand utilization and cost variation at the PIHP and member level and allow for the calculation of quality metrics.

The above processes will be followed by the CCBHCs to ensure that the State collects the necessary data to develop CCBHC cost reports within 9 months after the completion of the demonstration year. The required data elements will be identical for each CCBHC.

B.9 – Describe how state will establish PPS for BH services provided by CCBHCs.
During the rate setting process for services covered under the State's existing specialty services waiver, the actuary develops and analyzes the data for the entire PIHP system based on morbidity, treatment prevalence, utilization and unit cost. Other actuarial adjustments are made including adjustments for trend and other program adjustments, such as population mix changes. Estimated non-benefit expenses for administrative services and margin are included in the final capitation rates. Payments between the PIHPs vary based on clinical risk differences between their covered populations, based on factors such as the prevalence of developmental disability, serious mental illness, and other demographic factors.

A similar process will be extended to the clinic-level to develop actuarial sound rates. However, there are several key differences between the PIHP rates and the PPS-2 rate:

- ***Payment Based on Eligible vs. Treated Members.*** CCBHCs are paid only on beneficiaries receiving services, while the PIHPs are paid for members eligible for services. The development of our payment methodology will assess the need to further stratify the CCBHC rates based on the more specific criteria.
- ***Covered Services.*** The development of the CCBHC rates will assess the differences in covered services between the existing specialty services waiver and additional services that may be required to meet certification levels for CC PPS-2. To the extent additional

services will need to be covered to meet certification levels, we will estimates these expenses and incorporate them into the cost reporting and encounter process for future analysis. This will also support a process to identify and track the increased expense in isolation. Additionally, we will adjust the existing rates to the PIHPs to the extent the CCBHC PPS rate and its covered services overlaps with the PIHP rate.

- ***Special Populations.*** The CC PPS-2 rate setting process permits the designation of special populations to adjust the PPS rate between CCBHC. Using historical data from the PIHP delivery system, we will stratify historical clinical conditions and co-morbidities to determine conditions associated with above average costs.
- ***Outlier Payments.*** Based on historical PIHP costs, we will develop cost percentiles for members that are receiving services in a given month similar to those covered under the CC PPS-2 rate. Analysis will allow us to quantify what level of monthly cost should constitute an outlier, and incorporate findings into the outlier payment for the CCBHCs.
- ***Quality Bonus Payments.*** The CC PPS-2 payment methodology requires a state to incorporate quality bonus payments (QBP). QBP are currently not used in the State's specialty services waiver. The process for including QBP in the CC PPS-2 payment methodology will include:

Historical Benchmarks. The State and its consulting actuary will analyze historical PIHP encounter data and fee-for-service pharmacy data to establish baseline metrics for populations that are likely to be served by a CCBHC. The analysis will include examining the variation of results across the PIHP delivery system, as well as benchmarking quality measure results to industry standards.

Establish Minimum Standards. The State will establish minimum standards for each quality measure by CCBHC based on discussions with the delivery system. The minimum standards may vary between each CCBHC based on historical data. We anticipate that to receive the QBP in demonstration year 2, the minimum standards will be increased relative to the prior year.

Determine QBP amounts. QBP payments will be determined based on analysis of historical PIHP experience to determine potential cost savings associated with meeting the quality measures. To maintain actuarial soundness, the total amount of the QBP will not exceed 5% of the base rate.

Evaluation of Demonstration Year Experience. After the completion of each demonstration year, the quality measures will be evaluated for each CCBHC. We will also explore the need to make a credibility adjustment to the quality measures to the extent a CCBHC had a relatively low number of beneficiaries meeting criteria to be included in the development of a specific metric.

QBP Issued. To the extent a CCBHC meets the QBP measures, payments will be made on an annual basis to the CCBHC within 9 months of the completion of the prior demonstration year.

Trend rates. The State is open to the idea of using the Medicare Economic Index to trend the demonstration year 1 rates to year 2. Additionally, trend rates can leverage the extensive data already collected within the specialty services system to develop a more Michigan-specific trend.

We do not anticipate that any regulatory changes will be necessary to transition from current model to CCBHC model.

B.10 – Identify other organizations that will participate in the proposed project.
The MDHHS planning grant proposal development team was established seven months prior to SAMHSA's release of the RFA and is comprised of key decision-makers from the MDHHS Behavioral Health and Developmental Disabilities Administration (BHDDA), MDHHS Medical Services Administration (MSA), and the Michigan Association of Community Mental Health Boards (MACMHB). This project benefits from prior collaborations which successfully achieved federal support for a Dual Eligible Demonstration program, a Medicaid Health Home State Plan Amendment, Michigan's State Innovation Models, Blueprint for Health Innovation grant, MI-PICT primary care transformation, and Community Hub Projects. Outcomes achieved and processes developed from all of these programs can be leveraged for the CCBHC. An MDHHS MOA and letters of commitment from a wide range of critical partners who have committed to making the CCBHC a success are included in Attachment 1.

Organization	Role/Responsibilities
Michigan Association of Community Mental Health Boards (MACMHB)	MDHHS and MACMHB have been working closely on CCBHC planning since Fall 2014. MACMBH expresses strong support for the CCBHC to enhance outcomes for Michigan citizens relative to improved access and coordination and integrated care; improved certification process to guarantee care outcomes, and improved data and population management.
Department of Veterans Affairs	MDHHS and the VA have been working toward improved collaboration for the past several years and can expand efforts to support CCBHCs. Specifically, we see this occurring through improved access to veterans to the full continuum of BH services offered through the CCBHCs, regardless of where they live in MI.
Michigan Veterans Affairs Agency (MVAA)	MVAA sites previous work together and suggests CCBHC helps expand "no wrong door" access for veterans and more widespread access to BH and SUD services for veterans.
Battle Creek VA Medical Center (BC VMC)	BC VMC anticipates that CCBHC supports veterans' improved access to community based BH services, regardless of proximity to a VA.
Behavioral Health Advisory Council (BHAC)	BHAC group comprised of 55% consumer membership, which is defined as individuals and family members with lived experience who are not providers or state employees. Also represented are state agencies, advocacy organizations, the Michigan Primary Care Association, Tribal Health, corrections agency, and local service providers.
Michigan Association of Health Plans (MAHP)	MAHP committed to expanding our long-term efforts at facilitation total integration of services toward the best interest of facilitating whole-person care.
American Indian Health and Family Services of Southeastern Michigan	This group sees views CCBHCs as an opportunity to improve high quality, culturally appropriate mental health and substance abuse services to AI/AN peoples throughout the state.
Pokagon Band of Potawatomi	Specific interest relative to addressing the common challenges of: access to residential treatment centers, access to psychiatric services, Medicaid reimbursement, and sustainability efforts.
The Michigan Disability Rights Coalition	Provides their strong support to the further expansion of peer supports and services throughout Michigan through the CCBHC opportunity as well as for the expansion of peer cross-community collaboration and advocacy.
Mental Health Association of Michigan	The Mental Health Association in Michigan offers its commitment most specifically to goals of primary and behavioral health care integration, recovery based person-centered planning, expansion of multi-disciplinary community

Organization	Role/Responsibilities
	support teams, and 24 hour mobile crisis access across the state.
National Alliance on Mental Illness (NAMI)	NAMI Michigan shares our commitment to using CCBHC as an opportunity to reduce stigma as a barrier to access to care, especially among minority communities. Michigan Primary Care Association (MPCA) offers it support to the CCBHC planning grant to further integrate primary and behavioral health care and to plan further expansion of CCBHC and FQHC opportunities in Michigan.
Michigan Department of Correction (MDOC)	MDOC is views the CCBHC opportunity as critical for all Michigan citizens. In particular, they reference the importance of expanding current peer services pilots to prison environments throughout the state and to prisoner re-entry programs.
Michigan State Housing Development Authority	MSHDA identifies several areas of critical coordinated work and shares its commitment to especially addressing mental health services for persons experiencing homelessness, integrated care, and community integration.

B-11 Describe how state will work with CCBHCs to develop process of board governance.
The Core Values document described earlier in this application places strong value on the role of consumer and stakeholder leadership and governance in CMHSPs and PIHPs. Local FQHCs have governance models that also reflect similarly strong value for these perspectives. Most CMHSPs in Michigan meet or exceed the required standard for primary and secondary consumer representation on their Boards. We embrace the opportunity offered by CCBHC to expand that consumer and stakeholder role in leadership and governance.

To ensure necessary implementation speed and leverage existing statute, Michigan proposes to meet the CCBHC Program Requirement # 6 via criteria 6.b.3, which offers an alternative to requirement 6.b.1 and 6.b.2. In Michigan, the CMHSPs are part of a local government behavioral health authority. As such, the statutory basis for the establishment of CMHSPs grants the authority for the appointment of the board to the counties forming the CMHSP. The Michigan Mental Health Code presently supports meaningful input from consumer, persons in recovery and family members in section 330.1222 by requiring that at least one third of the Board membership be primary consumers or family members, and of that one third at least one half of those members shall be primary consumers.

In addition, the state of Michigan requires specialty behavioral health services, PIHPs and CMHSPs to promote meaningful advisory input of persons served. Their contracts include the Consumerism Practice Guideline (7.10.2.3) forms the basis of provider evaluation. The Family Driven Youth Guided Policy and Practice Guideline (7.10.2.5) also requires System Level Action Strategies, including: policies that ensure all provider incorporate parent, care giver and youth on decision making groups, boards and committees that support family driven, youth-guided practice. These policies must ensure training, support and compensation and specify engagement in design, evaluation and implementation. Representation is required to reflect the population and communities served. Implementation of these requirements are presently evaluated by annual state and PIHP level review of CMHSPs.

Section C: Staff, Management, and Relevant Experience
C.1: Capability and experience of the applicant and participating organizations with similar projects and populations.

BHDDA has been responsible for the administration and coordination of public funds (Medicaid, State General Funds and federal block grants) since 1998. As an example of the MDHHS, BHDDA and MSA interdepartmental oversight and collaboration, CMS awarded Michigan a SIM Design award in 2013 that resulted in the development of the "Blueprint for Health Innovation" (Blueprint). The Blueprint's overarching vision is to provide better health, better care at lower costs for every Michigan citizen. Michigan was also one of the early States to seek and expand Medicaid coverage through its HMP, including behavioral health and SUD services, and currently covers over 592,313 Michigan citizens. Additionally, the BHDDA Office of Recovery Oriented Systems of Care (OROSC) and partnering organizations (including PIHPs, CMHSPs and other community SUD providers) partnered in the development of a successful SAMHSA Strategic Prevention Partnership for Success Grant Application submitted in December, 2014. BHDDA brings over 17 years of experience of leadership, management and oversight of services to persons with Severe Mental Illness, Children with Severe Emotional Disturbance and individuals with SUD (including substance use prevention).

C.2: Complete list of staff for project, including Project Director and other key personnel. Although not directly funded by this project the *BHDDA Deputy Director, Ms. Lynda Zeller, M.P.A,* will provide oversight and guidance to this project. This position provides policy leadership for public behavioral health and developmental disabilities services, and exercises executive and administrative direction and oversight for operations through the Bureau of Community Based Services, Bureau of Hospitals and Administrative Operations, and the Children and Adults with Autism Spectrum Disorders Section. Ms. Zeller has more than 27 years of experience in the field of behavioral health, serving seriously mentally ill adults, seriously emotionally disturbed children, persons with developmental disabilities and those with SUD. She has served in executive positions with various health care and non-profit agencies, most recently as the Health Services Administrator for the Michigan Department of Corrections, which included all health, behavioral health and dental services for the correctional system.

The ***Project Director*** *(50% FTE)* will be *Eric Kurtz, M.A., HAD,* a Behavioral Health Executive with over 30 years of progressive work experience including direct provision of clinical services and management and oversight of finance, procurement and information systems in both urban and rural settings. With this combination of clinical and administrative experience, Mr. Kurtz offers a track record and ability to cultivate productive relationships among diverse cultures and to manage projects achieving leadership objectives. Mr. Kurtz was most recently the Executive Director of the Washtenaw Community Health Organization (WCHO) that as a PIHP managed over $114 million in Medicaid, State, local and general funds for pubic behavioral health and SUD services. As part of Mr. Kurtz's tenure, the WCHO spearheaded and fostered the Department of Community Organization and Development for the sole purpose of developing and sustaining an outreach program from commonly underserved populations that included children, families and older adults to members of racially, linguistic and culturally diverse communities within Washtenaw County. Mr. Kurtz was also the Co-Primary Investigator on the WCHO's successful Primary and Behavioral Health Care Integration (PBHCI) grant of 2008.

The ***Project Manager*** (33% FTE) will be *Erin Emerson, B.A., M.S.W.* Ms. Emerson joined the MSA Office of Health Care Reform as a Specialist in October 2014 after 6 years of prior state service supporting the Director of the State of Michigan's child care subsidy program for low-income families. In her current role, she serves as the liaison between the Medicaid and BHDDA

and assists the State Medicaid Director on a range of special projects. Ms. Emerson holds a Bachelor's degree in Psychology and Sociology from the University of Michigan and a Master's of Social Work from Columbia University. During her graduate studies, Ms. Emerson completed a clinical internship working with individuals living with HIV/AIDS and co-occurring SMI and SUD, as well as a policy internship exploring creative approaches to housing for individuals experiencing chronic homelessness due, at least in part, to SMI or SUD.

The ***Project Evaluator*** (60% FTE) will be *Kenyatta Jackson*. Ms. Jackson has worked with the State of Michigan as an Analyst for less than a year, yet brings 20 years' public health experience as an administrator and research analyst at municipal and federal levels of government and as an educator at two state universities. Ms. Jackson has served as a Social Science Analyst with the Veterans Affair Hospital Research Service, focusing on the National Cancer Institute Polyp Prevention Trial; as a senior-level Policy and Planning Analyst and later Consultant with the Department of Health and Wellness Promotion in Detroit, as an Adjunct Lecturer at Eastern Michigan University, and an Instructor at the University of Michigan.

The ***Site Review Coordinator*** (35% FTE) will be *Jody Lewis*. Ms. Lewis has over 35 years of experience within MDHHS. Ms. Lewis has had a wide range of duties from the development of group home curriculum and the certification responsibilities of CMHSPs. Ms. Lewis's ability to compare and review materials for completeness and adherence to a set of standards as well as her ability to communicate effectively and her history to coordinate and work with CMHSP supervisory personnel, will be a valuable asset with the CCBHC certification process.

The ***Project Coordinator*** (15% FTE) will be *Jared Welehodsky, J.D.* Mr. Welehodsky has been an analyst in the Health Policy and Innovation division of MDHHS for six months. Mr. Welehodsky is coordinating the implementation of Michigan's Mental Health and Wellness Commission's recommendations, as well as, providing support to Michigan's Prescription Drug and Opioid Abuse Task Force. Mr. Welehodsky will provide research, writing, and coordination with broader MDHHS health policy initiatives during this planning period. Prior to working at MDHHS, Mr. Welehodsky was a legislative assistant in the Michigan State Senate for over four years. Mr. Welehodsky performed constituent services and community outreach in a State Senate district that was both urban and rural in medically underserved Flint and Genesee County.

C.3: Demonstrated Experience of Key Staff.

All key staff members identified above have experience in and are familiar with cultures of the populations in the sub-recipient and sub-grantee communities through their previous work experience. Some key staff members also have personal experience with the cultures identified in addition to their professional work. All CCBHC Planning Grant Staff are required to be in compliance with: a) the state's Limited English Proficiency Guidelines promulgated by the Michigan Department of Civil Rights; b) Persons with Disabilities Civil Rights P.A. 20 1998; and c) State of Michigan Reasonable Accommodation Procedure as promulgated in Section 504 of the Rehabilitation Act of 1973. In addition, all funded program staff is in accordance to a plan that shows clear evidence of how age, culture, ethnicity, language, gender, and disability are considered. The state building that houses the CCBHC Planning Grant is accessible and in compliance with the Americans with Disabilities Act (ADA) and environmental requirements

(See Assurances). Any Sub-recipient under contract with MDHHS must also be in compliance with the ADA and other environmental regulations required by the state.

D. Data Collection and Performance Measurement

D-1 Document ability to collect/report required performance measures. Describe plan for data collection, management, analysis, and reporting.

Ability to collect and report on the required performance measures. Using the CCBHC Planning Framework, the Program Evaluator will collaborate with potential CCBHCs, PIHPs, MDHHS, and other state-level partners to ensure consistent interpretation, collection, tracking and reporting of required performance measures. Michigan currently implements a number of large-scale initiatives that require the collection of many measures similar to those specified throughout the RFA, particularly those mandated for receipt of CCBHC planning grant funds. However, the CCBHC Planning Framework will ensure that input from a broader range of stakeholders, including consumers, veterans' organizations, rural and local community organizations is reflected incorporated, as appropriate, into the data collection and data management process. For instance, **Michigan's Mission-Based Performance Indicator System for Persons with Mental Illness, Developmental Disabilities, Emotional Disturbances, and Substance Use Disorders (MMBPIS)** provides comparative reports on the performance of PIHPs in serving persons eligible for the state's specialty mental health, SUD and DD waiver. The indicators include, but are not limited to, measures on timeliness of service in emergent and non-emergent situations, service following discharge from an inpatient facility, and percentage of readmissions to inpatient facilities.

The state also maintains large data systems necessary for supporting state and federal collection and reporting requirements. They include:

837 Encounter Data for Behavioral Health is collected and reported for every beneficiary for which a claim was adjudicated or service rendered during the month by the PIHP regardless of payment source or funding stream. Encounter data reflects services for which providers were paid (paid claims), third party reimbursed, and/or any services provided directly by the PIHP. Effective October 1, 2015 Michigan will have a single client-level data collection system for all *behavioral health services or BH-TEDS.* Data such as living arrangement, employment status, reported income, education, substance use problems and frequency of use, social supports, criminal justice status, and arrest history are collected at the provider level for at least two points in time including at the start of service, at annual update and/or at end of service. Outcome measures are calculated by measuring the magnitude and direction of change of the various data fields. Data can be analyzed by the department at the provider, county, CMHSP, PIHP and state level. Since BH-TEDS is SAMHSA's national client-level data collection system, state-level outcomes and measures can also be compared nationally.

As well, with the implementation of *Medicaid Health Home* services for individuals with serious mental illness, Michigan developed of a comprehensive array of required and optional performance measures, including many of those required for participation in the CCBHC demonstration and enumerated in Appendix A: Quality Measures and Other Reporting Requirements and those contained in the PPS Guidance related to metrics for Quality Bonus

Payments (QBP) (e.g., follow-up after hospitalization for mental illness, initiation and engagement of alcohol and other drug dependence treatment, plan all-cause readmission rate).

***Planning for data collection*:** To prepare for state and provider-level collection and reporting of the Health Home measures, the state convened a Technical Workgroup designed to establish an information infrastructure as well as prepare state and provider staff for necessary changes in electronic health record (EHR) systems, provider clinical information systems (CIS), Medicaid management information systems (MMIS) and other systems. Building upon the success of this model in Health Homes, a similar work group will be utilized for development and implementation of CCBHC performance measures. The Knowledge Transfer Group, which will be established to provide a forum for planning and demonstration participants to discuss implementation topics and share best practices, will have six main tasks during the planning period:

1. Resolving data capacity issues across BH providers, health plans and the state agencies to facilitate peer learning across BH providers in use of state-level data to
2. Supporting further use of state-level, cross system data to conduct population health management data analytics;
3. Facilitating health information technology (HIT) and (health information exchange) HIE solutions to CCBHC, including developing provider-specific strategies to promote collaboration on HIE;
4. Developing providers' capacity for developing registries to support population health management;
5. Developing a data plan to populate dashboard/monitoring and reporting templates for capturing and reporting CCBHC milestones and metrics and to accomplish required CMS reporting.
6. Agreeing on and executing a plan to provide ongoing data supports (who does what: state, CMHs, PIHPs, MHPs), especially to monitor and address solutions for data access, programming for WSA/CC360 enhancements and analysis, reporting.

Plan for management, analysis, and reporting of data: Data gathered throughout the planning period (and into the demonstration period) will be aggregated for individual CCBHCs and across the state for all CCBHCs to comply with reporting requirements and to facilitate use of the data collection and analysis to support the state's quality improvement processes. Much like the current process for performance measure monitoring within the state, data will be evaluated quarterly (for the previous reporting period) at the state-level Quality Improvement Council. Additionally, any CCBHC specific performance monitoring data would be reviewed regularly by the assigned MDHHS CCBHC Coordinator, CCBHC Steering Committee and shared with the CCBHC Consumer Advisory Committees for identification of system wide performance issues and system-level needs for competency development and enhancement.

D-2 Describe how state will support CCBHCs as they build performance measurement infrastructure and implement continuous quality improvement processes.
Similar to the structure and process established for the Medicaid Health Home Technical Workgroup, the Knowledge Transfer Group will be comprised of the community mental health services programs (CMHSPs), tribal organizations, FQHCs likely to be included in the CCBHC

Demonstration, staff from the state Medicaid agency (MSA) and state mental health authority (BHDDA), PIHPs and the state's Medicaid data analytics vendors.

The governance structure of the Knowledge Transfer Group will include experts from CMHSPs, PIHPs, and FQHCs with extensive experience collecting, tracking and reporting performance measures using sources including provider EHRs, CareConnect 360 (or CC-360, Michigan's online, claims-based electronic health record is being made available to the state's 46 CMHSPs). To ensure continuity in communications across the entire initiatives, members will also include key individuals from the CCBHC Steering Committee and the CCBHC Advisory Group.

Similar to the Health Home Technical Workgroup, planning and implementation processes of the Knowledge Transfer Group will be informed by a project charter (which will specify the aim and purpose of the Group) and a comprehensive work plan that lays out priorities, lead staff, resources and timelines. That Group will further provide TA to inform and support use of the data in quality improvement process for the demonstration sites. They will work in partnership with the Program Evaluator and other PIHP and CMHSP Quality Improvement leads throughout the state (likely via one of the 3 Quality Improvement, Information Technology, and Finance conferences conducted annually within the state) to support use of the new data metrics in the system for quality improvement purposes.

D-3 Describe plan for conducting performance assessment; document ability to conduct.
Using the CCBHC Planning Framework and through collaboration across committees and work groups, the Program Evaluator will be responsible for conducting the performance assessment for the planning grant. Data will be collected using the uniform data collection tool provided by SAMHSA and then reported quarterly using the Common Data Platform (CDP) web system. Written quarterly reports will be submitted within 15 days from the end of the reporting quarter and data collected will include the number of:

- organizations or communities implementing mental health/substance use-related training programs as a result of the grant;
- people newly credentialed/certified to provide mental health/substance use-related practices/activities that are consistent with the goals of the grant;
- financing policy changes completed as a result of the grant;
- communities that establish management information/information technology system links across multiple agencies in order to share service population and service delivery data as a result of the grant;
- and percentage of work group/advisory group/council members who are consumers/family members;
- organizational changes made to support improvement of mental health/substance use-related practices/activities that are consistent with the goals of the grant; and
- organizations collaborating/coordinating/sharing resources with other organizations as a result of the grant.

For existing grant projects, the state periodically reviews performance data reported to SAMHSA to assess Michigan's progress and use the information to improve management of grant projects. In order to monitor service provision, expenditures and consumer outcomes, the MDHHS currently requires CMHSPs and PIHPs to provide information and data on topics such as costs,

services, consumer demographics, and administrative activities. Specifically, CMHSPs must provide the state mental health authority with uniform data and information to measure the CMHSP's accomplishments in the areas of access to care, utilization, service outcomes, recipient satisfaction, and to provide sufficient information to track expenditures. Additional performance measures required for CCBHCs (i.e., expansion of the data collection from Health Homes in Michigan to all CCBHC demonstration sites), will be incorporated into the existing performance measure monitoring processes for PIHPs such as the MMBPIS process described above.

Data aggregated by the state from the current performance monitoring system is evaluated quarterly (for the previous reporting period) at the State level Quality Improvement Council. This process will be implemented similarly for the CCBHC Demonstration. Additionally, any CCBHC-specific performance monitoring data will be reviewed regularly by the assigned Project Director and shared with the CCBHC Steering and Advisory Committees for identification of system wide performance issues and system-level needs for competency development and enhancement.

D-4 Discuss potential challenges in collecting data required national evaluation.
Michigan is currently embarking on a process and structure to inform ASPE's preliminary evaluation of the Medicaid health home benefit and is using the format of the Health Home Technical Workgroup to prepare for the ASPE site visits. In addition, the state continues to provide direct TA and ongoing training to Health Homes to clarify training and performance expectations with respect to tracking, collection and report of data. Michigan is prepared to collect the data required for the national evaluation and does not anticipate major challenges to its implementation given our experience in implementing similar efforts and formation of the Knowledge Transfer Group to solidify a common outreach, communications and training mechanism. Some adjustments will be necessary within the context of the existing behavioral health system processes to strengthen this capacity (section D.6 for more detail), tailoring aspects of the data and operational environments to meet the design. The ability to provide input on the evaluation design, data sources, and performance measures will assist in this process.

The likely challenges are faced by providers (especially those in rural communities) in the application of standardized data collection process for consumer-level data. Challenges will likely be related to the following:

Challenge	Options for mitigating challenges in year 1
Data (calculation of the measures) from providers that will be different and need to be normalized	• infrastructure established for learning communities, • practice transformation coaching • Internal business processes established for state-level staff to interact with CCBHCs and directly address training/TA needs (e.g. regularly occurring meetings with Medicaid to generate reports and establish alternative interim collection methodologies when state IT systems are unable to be modified in a timely manner). • Single reporting format across CCBHCs to ensure early and consistent understanding of reporting expectations. • Workgroups will be established to determine how
Difficulties in obtaining data from DCOs to CCBHCs to the state (especially fifteen days after the end of the quarter)	
Difficulty obtaining data from comparison groups from providers and in communities where equivalent data is not collected in the same manner as collection for CCBHCs	
The necessity for data sharing agreements	
Participation of managed care organizations for data elements collected outside of the CCBHC	
Data elements that are not currently collected by providers (e.g., providers may have EHRs in place but may not have enabled the functionality to track specific	

data components) Timeliness of receipt of claims data Inadequate data from encounter claims Lack of clarity on how measure should be calculated for non-NQF measures Data formats may be different and impact aggregation	measures will be defined and calculated across CCBHCs. • Support to CCBHCs to collect their own data and data from DCO if relevant. • State leadership will clarify and communicate expectations for cooperation across CCBHCs and other providers likely to be affected by data reporting to inform the national evaluation

Michigan expects to mitigate the challenges through the CCBHC Planning Framework, specifically through the activities of the Knowledge Transfer Group, which will help will aid in our ability to identify barriers and determine where adjustments in training or TA may be necessary in order for CCBHCs to accomplish intended outcomes objectives.

D-5 Describe a plan for selecting a comparison group.
During the planning grant phase, the comparison group will be modeled after the state's experience establishing a comparison group for Medicaid health home services. We will consult with Milliman who has been the consulting actuary for the state of Michigan for over 15 years. CCBHCs will likely be implemented in targeted geographic areas across the state. Changes in total per member per month (PMPM) health care costs and other metrics will be evaluated over time for two distinct populations, those receiving services at a CCBHC and those not receiving services at a CCBHC. Those not enrolled in a CCBHC will serve as the control group.

The control group will be developed by developing a like population from regions not receiving services from a CCBHC and analyzing the control group's costs and other metrics over the same period of time as the intervention group. Other adjustments will be made to the control group to adjust for factors that may influence costs outside of CCBHC intervention. These adjustments included age/gender, eligibility group; geographic, including urban/rural differences; impact of members opting out of the program; and other risk adjustment techniques. The PMPM costs and other metrics for the intervention population over the course of the program will be tracked and analyzed. It will then be compared to the PMPM costs and other metrics of the control group population. Adjustments will also be made for beneficiaries that are cost outliers in both the control and intervention groups.

For the above described cost savings calculation and cohort development, all behavioral health services including inpatient, emergency, and ambulatory services will be included in the PMPM cost and metric construction. To ensure the most accurate comparison between the control group and the intervention group, the same data collection methods will be used for both years, such as using the same amount of claims run out.

Michigan will utilize the planning grant funds and rely on the National program evaluation infrastructure to inform the formal methodology, including selection of a comparison group for an assessment of access, quality, and scope of services available to Medicaid enrollees served by CCBHCs compared with Medicaid enrollees who access community-based mental health services from other providers.

D-6 Describe the capacity to collect data to inform the national evaluation.

The CCBHC Program Evaluator, through the CCBHC Planning Framework, will be charged with ensuring that the state is prepared to participate in the national evaluation for the demonstration program. The CCBHC Program Evaluator will work with the Knowledge Transfer Group, Steering Committee, and Advisory Group to refine statewide data systems to comport with evaluation requirements. As well, the state will ensure that the CCBHC Planning Frameworks enables the regular performance of data analytics with encounters and other patient records will support local efforts to inform the national evaluation. As appropriate, the Program Evaluator will also work directly with a non-profit institute with which MDHHS has a longstanding relationship and that specializes in services to support community health including the provision of comprehensive program evaluation and research expertise.

MDHHS has a robust electronic environment comprised of several components for managing claims/encounters, patient records, chart-based/registry data, and patient experience data. Together these systems support the State's capacity to inform the national evaluation of the demonstration program and are described below:

Capacity to collect claims data: Michigan's *Community Health Automated Medicaid Processing System* (CHAMPS) comprises the claims processing aspect of the State of Michigan's electronic health information environment. Through the Claims and Encounters (CE) subsystem of CHAMPS, all state affiliated providers, including PIHPs, submit standardized electronic data interchange (EDI) health encounters/claims as 837 encounter transactions. PIHPs submit 837 encounter data for every beneficiary for which a claim was adjudicated or service rendered during the month by the PIHP (directly or via contract) regardless of payment source or funding stream. As PIHP business practices do not include claims payment, they currently receive capitated payments. The state is considering CMHSPs that regularly submit timely encounter data with consistent attention to integrity for participation in the CCBHC demonstration program.

Encounter Data: Michigan's Data Warehouse houses data tables from various Michigan departments, agencies, and programs and affords the integration of data across agencies. This system allows access to electronic health record tables to perform analysis of services rendered to persons who received services in the behavioral health system (Medicaid and non-Medicaid). *Open Intelligence BIQuery* is used by state employees to perform analytics of the CHAMPS encounter data and to do so in conjunction with data regarding services, diagnoses, and the demographics of patients. Michigan will recommend consideration of a Healthcare Procedure Coding System modifier at the national level for the purpose of flagging CCBHC services and patients, and simplifying evaluation related analysis. However, upon determination of the CCBHCs that will participate in the demonstration program, the capacity is well established to perform queries using the names of those centers and the existing national coding for demonstration program services.

Patient records, chart-based/registry data: As a care management web portal, Michigan's *Care Connect 360 (CC360)* was created and recently launched as an electronic resource for coordinating care while addressing any unmet needs individual patients may have; integrating service delivery and provider collaboration all patients, closely monitoring the integration process for those who are Medicaid and Medicare Eligible (MME). Drawing information from

the Data Warehouse, CC360 is an initiative by the State toward integrating behavioral health services with physical health services in the electronic health records used for analytics. MHPs, PIHPs and CMHSPs have access to Medicaid claims for both aspects of care through the portal. The State hopes CC360 will assist in identifying potential health conditions in individual patients. At the aggregate level, this tool will be useful determining quality measures and in viewing trending information at various levels including data specific to PIHP/CMHSP organizations. Though there are some limitations to the use of this tool that are discussed in section D.4., the Workgroup is strategizing around the use of CC360 for tracking data specific to CCBHCs and patients receiving services designated for the demonstration program.

Patient Experience: Michigan will leverage stakeholder involvement in the CCBHC planning process to develop a more cohesive plan for measuring and tracking patient experience among CCBHCs, based on local and regional CMHSPs annual need assessments, which require involvement from current consumers, as well as consumer experience feedback elicited from PIHP/CMHSP organizations. The methods of these activities vary at present and require attention during the planning period to ensure that robust and meaningful systems, processes, and methods are routinely utilized across the CCBHCs.

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